Survey of undergraduate teaching in genitourinary medicine in Britain

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Abstract

***Objective*—To determine whether the time allocated for undergraduate teaching of genitourinary medicine has changed since 1984 and to determine the impact of HIV/AIDS on the teaching of the specialty.**

***Methods*—A self completion questionnaire was sent to the consultant in charge of each department of genitourinary medicine attached to a UK medical school.**

***Results*—Replies were received from all twenty seven medical schools. Most schools (24/27) offer a course of lectures accompanied by clinical teaching; however, one medical school does not include teaching of genitourinary medicine in the undergraduate curriculum at all and two others are unable to offer all students clinical tuition. The mean time devoted to lectures is 6·7 hours (range 0–15 hours) made up of 4·8 hours of genitourinary medicine lectures and 1·9 hours of lectures on HIV/AIDS. The mean time allocated for clinic-based teaching of each student is 9·2 hours (range 0–27 hours). On average the time allocated for lecturing and clinical teaching of the speciality has decreased since 1984 although there is considerable variation between schools (time for clinical teaching and lecturing combined ranges from 0–41·0 hours).**

***Conclusions*—The findings of this survey suggest there is considerable variation in both the quantity and quality of undergraduate teaching of genitourinary medicine provided throughout the UK.**

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Introduction

Surveys of undergraduate teaching of genitourinary medicine conducted in the UK in 1979 and 1984 suggested that the number of hours allocated for teaching of the speciality had decreased since the mid 1960s despite an increase in the prevalence of many sexually transmitted infections (STD).[1 2] Since then the emphasis and workload of many genitourinary medicine clinics has been dramatically altered by HIV and AIDS. In order to establish what effect this has had on undergraduate teaching we conducted a further survey of all departments of genitourinary medicine attached to UK medical schools. The main objectives of the study were to discover whether the time allocated for teaching has changed since 1984 and whether teaching time for HIV been allocated at the expense of teaching of other STDs.

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Methods

A self completion questionnaire was sent to the consultant in charge of the department of genitourinary medicine attached to each of the 27 medical schools within the UK. The questionnaire asked for both qualitative and quantitative information about the undergraduate teaching programme in that medical school.

Results

Replies were received from all 27 medical schools (response rate 100%).

One non-London medical school has had no time allocated for teaching genitourinary medicine for the last 4 years, but is hoping to be able to reintroduce some teaching into the curriculum in the near future. In 21 medical schools genitourinary medicine is taught in conjunction with other disciplines (six with obstetrics and gynaecology, six with medical microbiology/infectious disease and the remainder with a combination of other specialities) and in five it is taught separately.

All of the 26 medical schools which teach genitourinary medicine give lectures and the majority (24) are able to offer clinical teaching to all students. In 17 medical schools the lecture course is run concurrently with clinical teaching. The mean number of hours devoted to lectures is 6·7 hours (range 0–15 hours) made up of 4·8 hours of genitourinary medicine lectures (range 0–11 hours) and 1·9 hours (range 0–5 hours) of lectures on HIV/AIDS. Six schools give genitourinary medicine lectures once a year to all the students, 13 run 2–4 courses each year and six run 5 or more courses each year.

The mean time allocated for clinic-based teaching of each student is 9·2 hours (range 0–27 hours). Not more than one student is assigned to a doctor for clinical teaching in all but one medical school. In 17 medical schools students are given the opportunity to take histories from patients and in 20 to examine them. Additional teaching available to students is shown in table 1.

Fifteen departments have some means of assessing students performance at the end of the course, usually in the form of a multiple choice question paper (one medical school

Table 1 Additional teaching available to medical students

	*No of medical schools where teaching is available (n = 26)**
Laboratory/clinical demonstrations	14
Small group teaching	15
In-patient ward rounds	7
Teaching from health advisors/nurses	21

*1 medical school does not teach genitourinary medicine.

Table 2 Skills acquired by students during their training as assessed by consultants completing the questionnaire

What proportion of doctors qualifying from your medical school would you estimate could:	*<50%*	*50–80%*	*>80%*
Take a sexual history?	7	11	9
Perform a genital examination?	7	11	9
Understand sexual health issues?	7	11	9

Table 3 Quality of undergraduate teaching as assessed by consultants completing the questionnaire

	No of medical schools (n = 27)
Outstanding	3
Generally good	15
Mediocre, some improvement could be made	6
Poor (or non-existent)	3

uses short answer questions and one essay). Three medical schools also include project preparation, oral examination and/or essay questions in their assessment.

At 12 medical schools the students' reaction to the teaching course is elicited in writing by the medical school secretariat. In 10 it is elicited in the department of genitourinary medicine either verbally or in writing while in 4/25 no assessment of the students' reaction to their teaching course is made.

Participating consultants were asked to estimate what proportion of medical students qualifying from their medical school would be able to take a sexual history, perform a genital examination and have a good understanding of sexual health issues (table 2). Only nine felt that most of their students (>80%) would be able to do this. Of note, consultants at medical schools which had less than 15 hours of clinical teaching were significantly more likely to estimate that students at their medical school would be able to perform a genital examination than those who had more than 15 hours. There was no association between estimated ability to take a sexual history and length of time allocated to clinical teaching. Consultants were also asked to assess the quality of undergraduate teaching provided by their unit (table 3). The majority (18) felt that this was outstanding or generally good.

Table 4 compares the results obtained in the 1979 and 1984 surveys with this one. Only medical schools which took part in all three surveys are included (n = 23). Overall less time is allocated for lectures and clinical teaching of the speciality. Ten medical schools have more time for lectures than in the 1984 survey, three are allocated the same length of time and ten are allocated less (fig 1). Time for clinical teaching of students has also increased in ten medical schools since 1984, is the same in three and has decreased in ten (fig 2). In 1979 only five centres held clinical or laboratory examinations and two held small group teaching. At that time 70% of medical schools had a 1:1 doctor:student ratio for clinical teaching while the remainder had between 2–4 students allocated to each doctor.

Table 4 Mean teaching hours in genitourinary medicine in 1979, 1984 and 1993

	1979	*1984*	*1993**	
			General STD lectures	*All lectures*
Lectures	6·0	6·7	4·5	5·9
Clinical attachment	9·0	9·7	9·2	9·2
Total	15·0	16·4	13·7	15·1

*Only includes the 23 medical schools which took part in all three surveys

Discussion

The results of this survey give cause for concern in that the time allocated for undergraduate teaching of genitourinary medicine varies considerably from place to place. While some medical schools are able to offer a comprehensive lecture course accompanied by clinical teaching, tutorials and laboratory demonstrations others are less fortunate. One medical school has no undergraduate teaching of genitourinary medicine at all and two others are unable to offer clinical teaching to all

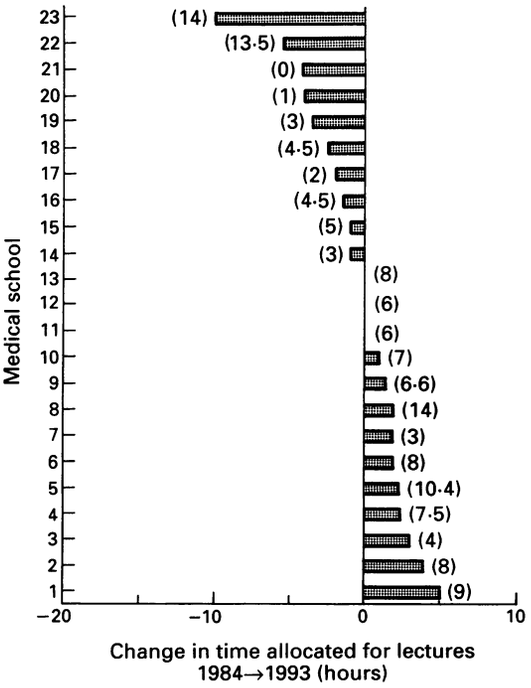

Figure 1 Change in time allocated for lectures between 1984 and 1993.

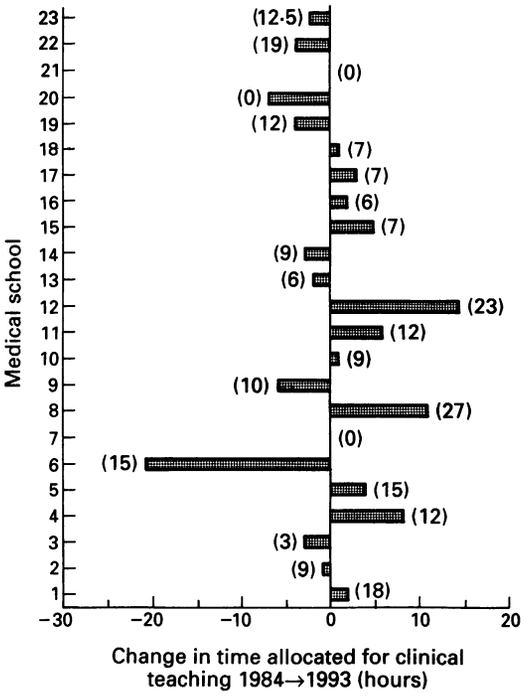

Figure 2 Change in time allocated for clinical teaching between 1984 and 1993.

medical students. Nine of the participating consultants felt that the undergraduate teaching offered at their medical school was, at best, mediocre. Only one third felt that over 80% of students from their medical school would be able to take a sexual history or perform a genital examination upon qualifying as a doctor. Several consultants mentioned that the time allocated to teaching of the specialty was under constant threat.

When comparing the results of this survey with those conducted in 1979 and 1984 it is apparent that on average there is less time allocated for both lectures and clinical teaching than there was then. Since the last survey was conducted many departments have broadened the scope of their lecture course to include HIV and AIDS without being allocated more time to do so. However, these average figures hide a considerable disparity between medical schools (time for clinical teaching and lecturing combined ranges from 0–41·0 hours). Those schools with least lecture time also have least time for clinical teaching.

More departments offer small group teaching than did in 1979 which may in part compensate for the reduction in teaching time. However, the mean lecture time in those who give small group teaching is 7·4 hours (range 2·0–15·0 hours) compared with 5·6 hours (range 0–14·5 hours) in those who do not. Although this difference is not statistically significant it suggests that those medical schools which allocate less time for lecturing also allocate less time for small group teaching.

On the other hand, since the 1979 survey the number of medical schools offering clinical teaching on a 1:1 doctor:student ratio has increased from 70% to 96%. One to one teaching, although intensive and time consuming, is likely to be more acceptable to both patients and students than the higher ratios used in some schools previously.

As teachers of genitourinary medicine we must decide what comprises an acceptable minimum in terms of teaching objectives for undergraduate training and then develop and refine the ways of attaining these. It is clearly important to get feedback from students and to make some assessment of what they have learnt in order to determine whether these objectives have been met. Without this it is easy to suppose erroneously that the aims of teaching have been achieved when this is unlikely to be the case. For example although 10 genitourinary medicine departments were unable to give students any opportunity to take a history from patients, consultants from two of these medical schools estimated that >80% of doctors qualifying from their medical school could take a sexual history and four estimated that between 50–80% would be able to do this.

It seems astonishing that the time available for undergraduate teaching of genitourinary medicine has decreased during the last nine years when the importance of learning about sexual health issues should be apparent to all. That any university can justify excluding the specialty from its teaching curriculum is extraordinary.

Addendum—A consultant from one of the participating medical schools has informed the authors that since completing the survey questionnaire undergraduate teaching of GUM at that medical school has become optional for some students rather than necessary for all.

1 Adler MW, Willcox RR. Teaching of genitourinary medicine (venereology) to undergraduate medical students in Britain. *Br J Venereal Dis* 1981;57:170–3.
2 Adler MW. Survey of medical undergraduate teaching in genitourinary medicine in Britain. *Genitourin Med* 1984;60:405.